SSB 5064 - Health Information Infrastructure Advisory Board (HIIAB)
Radisson Hotel, Seattle, WA
Session of August 25, 2005

HIIAB Session August 25, 2005

FINAL DRAFT == Summary of Proceedings == DRAFT

Welcome and Introductory Remarks

- **Introductions of HIIAB Members & HCA staff**
- **Call to Order**
- **Review of the Agenda**

Richard Onizuka, Director of Policy, HCA welcomed the board members/distinguished guests and the public and introduced each of the Health Information Infrastructure Advisory Board (HIIAB) members. Richard thanked Senator Thibaudeau, who attended the day's session for her support for the project. In a light moment, Marc Droppert the appointed board chair was presented with a block and gavel and he called the session to order. A discussion followed on what a preliminary timeline might look like timeline for the mandated deliverables: a preliminary report that is due December 2005 and the final report due December 2006.

Charge to HIIAB

- **Legislative requirements and context**
- **Role of HIIAB**
- **Guiding Principles**
- **Role of other stakeholder groups**

Richard Onizuka reviewed portions of SSB 5064 in particular the second section. Issues touched on by the Board were around cost and interoperability. Discussion on context was addressed from earlier conversations with proponent staff and from Senator Thibaudeau who addressed the board. HCA staff noted that if agency proposed Legislation was considered it would need to be drafted by January 2006. Roles for the Board that were discussed included:

- Research and identifying best practice electronic medical records (EMR) and health information technologies (HIT).
- Making recommendations
- Taking a lead role in encouraging the adoption of EMR and HIT
- Promoting systems and standards compatible with current EMR and HIT systems in use in Washington state
- Board should identify obstacles and provide policy recommendations to reduce or remove obstacles
- Advise stakeholders and legislature

Marc Droppert opened the discussion and the Board engaged in identifying concepts for guiding principles that the board can adopt. The Board discussed reasons for having

values and guiding principles and identified some preliminary ones. **For Action: HCA staff will take the preliminary ideas and provide the Board with a draft they can finalize at the September 22, 2005 session.**

Highlight comments from the Board on considerations for guiding principles:
Marc Droppert:

- Health record matching is an important issue and that the system should serve the best interest of patients.
- Trusted solution – balance patient's needs and business interest of the clinic.

James Hereford:

- Who will be trusted? Must have a trusted 3rd Party.
- There should be a business side to the solution that improves business practices as well as a clinical side to improve quality of care. Clinical dimension should relate to the business dimension.
- With the Federated model; need to insure privacy, sharing, and encourage cooperation in the market place.

Jeff Hummel:

- Primary groups have high anxiety in the loss of productivity when implementing an EMR system.
- There are also data tracking issues.

Alexis Wilson:

- Difference between data and information when it relates to interoperability. Data values in one system may not be the same as another system's.
- Access between hospitals, clinics, and providers needs to insure privacy for patients.
- Pay for performance in relation to actual outcomes that systems can achieve.

Background brief on National Health Information Infrastructure

- **State of Health Information Technology (HIT)**
- **Lessons learned**
- **Key issues and challenges for implementation**

Dr. Bill Yasnoff gave a background brief on National Health Information Infrastructure (NHII). Highlights of the presentation included information on:

- Errors in health care, the need for physicians to agree on practices for reviewing patient records, and cognitive challenges. Main issues include: error rates, quality inconsistent, reporting and sharing of data between health agencies & hospitals, technology is driving up the cost of health care, demographics, and bioterrorism.
- Reviewed national experts reports committee on data standards for patient safety established NHII as highest priority.
- What is NHII? Anytime, anywhere healthcare information and decision support. Not: a national database (Feds will not pay for NHII).

- Principles of NHII are: Privacy, patient centered, inclusive, private sector, voluntary, collaborative, align incentives, incremental, local, and interoperable.
- When establishing standards should not assume the "building" (referring to the slides) will automatically appear. Should include messaging standards for requesting information. Should have content standards with common terms which are important when sharing patient data.
- Elements of NHII: Decision support and education, profession, consumer, confidentiality, need to know, authentication, encryption, audit, and penalties.
- Functions: Immediate availability from all sources enable up to date decision support, selective reporting, tools (E-prescribing), and patient control of access to their records.
- Requirements: No identifier or national database, incentives, each facility maintain its own data, minimum cost and risk, and incremental approach.
- Current problems: VA system is automated but does not share data between facilities, records unavailable, relies on patient's memory, outcome errors, over use, and under use.
- Community health exchange system: E-records requested locally and data sent to facility doing inquiry. Local systems could be linked to form a national system and records could be maintained locally.
- Benefits: Local health care information sharing benefits local standard will help local HII to work with NHII.

Dr. Yasnoff also addressed current NHII Challenges:

- Confidentiality, standards, incentive, collaboration legal, and regulatory.
- Health care industry is not fully utilizing technology. Health care industry is fragmented, problems with change management, and no reimbursements system for IT costs.
- Inpatient electronic health record (EHR)
- Benefits hospital and larger health organizations; capital will be an obstacle for smaller health organizations.

Outpatient EHR

- Benefits to payer, pay incentives needed for physicians to participate.
- Community Health Information Exchange - First implementers will have the longest wait for ROI and seed money is needed.

Key Enablers for Effective IT

- EHR's – requires reimbursement reform
- CHIE – community health information exchange
- Interoperability
- Standards
- Interoperability

Key Issues

- Buy in
- Governance
- Ownership
- Finance
- Technology

NHII Strategic Principles

- Learn from others
- Build consensus
- Implement incrementally
- Do easy projects first
- Each step self sustaining
- Gradual implementation of comprehensive system

Background Briefing: Examples of Washington State activities

- **Group Health: Shared Medical Record**
- **INHS: Spokane Health Information Infrastructure**
- **Whatcom County: Personal Health Record Project**

Group Health: James Hereford

Group Health uses Epicare software and a web strategy that includes a website and portal where patients and doctors can view patient records, send secure messages between patients and providers. The goal as stated by James Hereford is to make things transparent to improve communications between patients and providers. Group Health started with a website and later integrated into a web portal where patients/providers could access patient records. System security requires that passwords and pins are mailed and activated within 15 days of receipt. Group Health accomplished this by first creating a records repository, then offering online access, and secure messaging. Group Health then installed and implemented at clinics. Patients can view their health records, view lab results, problem list, and contact their providers online. Over 100,000 of 380,000 patients (1 in 3) use the Epicare online system. James stated that people want it, the work load is manageable, and messaging is part of capitation for providers.

Group Health has found that the phone system is not an efficient way to communicate with patients, cost per call approx $13. The secure messaging system was implemented August 2003, is a part of the medical record, used to communicate between patients and providers regarding questions, and is used to schedule follow-ups. The online medical records portion of Epicare was implemented in 2004. A current issue pertinent to the work of the Board is that federal and state laws challenge who can access their health records online; one example is teenagers. Benefits to the system are affordability (pay back in 6 years), quality, safety, branding, and shared information (evidence based medicine). Cost is approximately $25,000 to $35,000 per provider.

Inland NW Health Services (INHS) (Spokane) – Tom Fritz

INHS is a non-profit organization serving communities in WA, ID, MT, OR, and Canada. Their electronic medical records system contains 2.7 million records, has digital image storage, prevents test duplication, offers inpatient or outpatient lab results, electronic availability (home or office), and is fully interface electronic health records. According to Tom Fritz the system is very affordable and costs less than 2% of a current organization's IT costs. The system interconnects physicians, personalizes care and improves population health. This system is used by 34 hospitals with 3,000 beds and

1,000 providers, 50 outpatient clinics and 400 providers, and blood banks. This system has a master patient index which links all of patients' records from outpatient clinics, hospitals, and other participating institutions. The software used is Meditech of Boston with a goal of integrating paperless medical records, web based system for inpatient and outpatient records.

INHS also has implemented a mobile Electronic Medical Record (EMR) system called Mercury MD. Mercury MD EMR supports palm handhelds, wireless, PP/PCP, and cell phones. The EMR is used by 1200 staff and 800 physicians. The EMR allows viewing of complete patient medical records by providers. Average EMR views per month are staff 36,000 and physicians 60,000. The EMR tracks who viewed what pages of a patient's medical record, when they viewed them and for how long. ROI benefits doctors and patients by increasing accuracy and makes the medical records available anytime. The EMR system also includes reports of health department data, which is pushed to CDC. The EMR system also has occupational health web portal to help patients manage their care and tracks evidence based medicine data. Lesson learned so far with this EMR are leverage of assets, effective cost plus model, standardization, and consolidation of bulk purchases savings.

Whatcom County: Personal Health Records Project – Marc Pierson M.D.
Patient Health Record (PHR) tracks chronic conditions, payments, and has navigator coaches. Is integrated with business and medical records costs so far is $2 million. The PHR system is integrated with care management (care managers, providers, and payments). Goals are that the system must work across payers and providers; connect anyone to patient's records, and offer home centered chronic care management. Ed Wagner's chronic care model was used to help design the system. Information focus shifts from EMR to PHR. Decisions made at home make a difference in chronic care.

Overview of work plan and process for HIIAB through Dec 2005 – Marc Droppert, Bill Yasnoff and the Board.

Preliminary report is due December 1, 2005. October meeting will further define what will be in the preliminary report and with a goal of having a draft outline or framework for the preliminary report. The final draft of the preliminary report needs to be complete before the November 17, 2005 meeting in order that the Board can perform a final review during the meeting.

Also discussed was a breakdown of elements of the report with outline suggestions:

1. Problem
2. Focus
3. Issues/challenges
4. Role of government

1. Problem ID
2. What the process will be
3. Statement of need
4. Benefits

Path to finding a viable solution

1. Problem description
2. Issues

3. Process description
4. Role the state can play to facilitate adoption
5. Conceptionalize how all players can make the change

Some discussion centered on whether this was a state solution to provide recommendations and/or assist with implementation?

Marc Droppert, Board Chair, encouraged full participation and engagement of Board members at proceedings. He touched on style issues and asked Board members to speak out regarding issues; otherwise lack of voicing opinion will be construed as agreement. Marc encouraged the use of e-mail to communicate and address issues on drafts or work products so what all board members could keep in synch with thinking, concerns and status.

Further discussion facilitated by Dr. Bill Yasnoff on describing "The Problem."
How will the Board go about the process, elements to include, and how to conceptualize objectives? Some highlights of that discussion included:

1. Availability of relative patient information where ever or whenever needed and a decision support system.
2. Availability of health decision support system with the goal of improving patient health.
3. Our current health system does not provide information that allows us to improve health. Our goal is to provide a system that provides health information and improves health.
4. Improve health of patients and a more efficient health care delivery system.

For Action: The Board also identified that there is a need to establish a set of criteria that "the solution" must have. A listing of issues were outlined, discussed and drafted on easel charts that will be finalized at the next session on September 22, 2005 by Dr. Bill Yasnoff.

Discussion of issues in collecting information raised by Board members included:

- Privacy; security; patient interaction and ownership of their health records;
- Affordability for small practices;
- Architecture, scale and incremental approach;
- Performance initiatives to leverage/increase participation; scope (secure messaging, etc.); and functionality (physician ordering, etc.).
- Is there a parade of systems in use to simplify this?
- Small providers – is this for them?
- Will market drive this solution?
- How does this operate public or private?
- Separate approaches for large or small institutions?
- Initial financing

The Board also discussed the use of metrics:

- If these things are done, how will we know that we are finished?
- Suggested metrics: cost, quality satisfaction

How to demonstrate value to stakeholders?

- Identify stakeholders other than buyer?
- Encourage universities to do research in this area?

Built in metrics and projects

- Baseline before project?
- Collect data during project to measure progress?
- Relationship to federal level – is this system designed for other than state level?
- Flexibility and scalability

Interested Party and Public Comment:

Jim King, Labor and Industries.

- Expressed a concern to the Board of indexing of information and that consideration be given to unique payer status of L & I since they insure conditions not loves.
- Include L & I requirements in the overall solution.

Bob Perna, Washington State Medical Association.

- Referred to application service providers (ASP) where there could be a "lease vs. buy" for EMR and EHRs.
- Not enough emphasis that one (as a provider) does not have to buy. Pleased that there is a raising of awareness
- What are the longer term objectives that the state may be looking to engage in this process? There are suspicions by providers and there is little data especially for small and midsize provider offices.
- The solutions should help with direct care. There is the issue of opening up data in practices; what is the expectation from the state on access to that data?

Tom Byron, Washington State Hospital Association.

- Identified an obstacle and an objective: Liability of using information that did not come from your organization.
- With a huge amount of pushing of data, how do you handle the "integration?"
- With the concept of "voluntary" the Board should consider how large a problem "opting out" is. How big could this "problem" be and how would the solution address this?
- "Opt out" consumers will still show up at hospitals and other providers. In the report, the Board will be well served to concentrate on addressing issues and questions and go light on "process."

Sandy Rominger, Boeing.

- Expressed concerns about liability and risk exposure and transferring risk.

- As a technology provider Boeing encourages the Board to consider describing the technology in terms of requirements for stakeholders much as Boeing does for "customers".
- Technology moves very quickly, so speak in terms of requirements.

Follow-up or Work to be Completed:

- Juan Alaniz and Dr. Bill Yasnoff will follow up with assigned tasks for further Board action.
- Juan and Dr. Yasnoff will provide the Board with documents and materials for Board review prior to the September 22, 2005 session.

Document Deliverables:

1. Guiding Principles draft for Board to finalize (Juan Alaniz)
2. Straw Draft: What's the Problem? (Dr. Bill Yasnoff)
3. "Outline and Framework" for the Preliminary Report (Bill Yasnoff)

Juan Alaniz Provide an Update on:

1. Stakeholder Advisory Committee
2. HIT / EMR Assessment in Washington State
3. HIT / HIIAB Web Page

Adjournment:

With no further business and with assignments confirmed, the Board was adjourned by the Chair at 4:45 P.M.